Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES

FAMILY SUPPORT PILOT QUESTIONNAIRE

NAME OF CLIENT		SOCIAL SECURITY NUMBER
SEX ☐ Male ☐ Female	DATE OF BIRTH	TELEPHONE NUMBER
NAME OF PARENTS/PRIMARY CAREGIVER		RELATIONSHIP TO CLIENT
STREET ADDRESS	CITY STATE ZIP CODE	

(You may use line 22 of your income tax 1040 form for the questions below. If the individual is 18 or over, list only their income).

GROSS ANNUAL HOUSEHOLD INCOME	NUMBER IN FAMILY

Number and ages of family members/others living in the home and their relationship to the individual (if more lines are required, use back of sheet).

NAME	AGE	RELATIONSHIP

CLIENT'S DISABILITIES

Identify the client's disabilities:

- ☐ Developmental Delays
- ☐ Mental Retardation
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Autism
- ☐ Epilepsy
- ☐ Another neurological or central nervous system disorder: _____
- ☐ Other condition or diagnosis: _____
- ☐ Client needs lifting and weighs more than 40 pounds.

COMMENTS

CAREGIVER CONCERNS

As the primary caregiver, check any of the following items that affect your current caregiving ability.

- ☐ Single parent
- ☐ Caregiver for two or more persons with disabilities
- ☐ Current physical or medical problems
- ☐ Current mental health or emotional problems
- ☐ Caregiving duties result in less than 5 hours of uninterrupted sleep most nights

The above information is true and accurate to the best of my knowledge.

LEGAL REPRESENTATIVE SIGNATURE	DATE